

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35287  
Registrar's No. 74

Registration District No. 217

Primary Registration District No. 30215

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Charleston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
204 Locust St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Luvenia Johnson  
3. (b) If veteran, name war. ----- 3. (c) Social Security No. -----  
4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Willie Johnson 6. (c) Age of husband or wife if alive 51 years  
7. Birth date of deceased Oct. 16 1889  
(Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 0 If less than one day hr. min.

9. Birthplace Warren County, Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business -----

12. Name John Briscoe

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Frances (Unknown)

15. Birthplace (Unknown) Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant Willie Johnson

(b) Address 204 Locust St.

17. (a) Burial (b) Date thereof Sept. 21, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director F. J. Sparks

(b) Address Cape Girardeau, Mo.

19. (a) Oct 1 - 43 (b) M. L. M. M.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Charleston 067  
(If outside city or town limits, write "RURAL")  
(d) Street No. 204 Locust St. 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ----- 11

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 16  
year 1943 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from 6-9- 1943, to 9-1- 1943  
that I last saw him alive on 9-1-43, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease 6 mos  
Duration

Due to shyotoxiosis 8 mos

Due to -----

Other conditions 93d  
(Include pregnancy within 3 months of death)

Major findings: -----

Of operations -----

Of autopsy -----

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) -----

(b) Date of occurrence -----

(c) Where did injury occur? ----- (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? -----

While at work? ----- (Specify type of place)

Means of injury -----

23. Signature M. L. M. M. (M. D. or other)

Address 204 Locust St. Charleston, Mo. 9/19/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 1043-1251

Date Filed 10-11-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Frank Sparks

Licensed Embalmer No. 3450

P. O. Address Cape Breton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.